

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03708

CERTIFICATE OF DEATH

03702

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT			
c. LENGTH OF STAY IN 1b 14 Hours				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN Adult Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT AND QUEEN ANNE'S HOSPITAL				d. STREET ADDRESS NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERMAN		Middle		Last BLACKWAY SR.		4. DATE OF DEATH Month MARCH Day 9 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/14/89		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wilmington Delaware KENT COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jas. Edward Blackway				14. MOTHER'S MAIDEN NAME Sarah Kirby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no YES		16. SOCIAL SECURITY NO. 215-05-2873		17. INFORMANT HOSPITAL RECORDS		Address CHESTERTOWN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal aortic aneurism, Possibly leaking. This was not definitely determined							INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/8/1967 , to 3/9/1967 , that (I) (we) last saw the deceased alive on MARCH 9 1967 , and that death occurred at 7:05am , from the causes and on the date stated above.							
22a. SIGNATURE DR. ROBERT FARR						22b. DATE SIGNED 3/10/67	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT FARR						22d. ADDRESS CHESTERTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/12/67		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR J. Wilho Wells Chestertown, Md.				25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03709

CERTIFICATE OF DEATH

03703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY KENT COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN lb 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN (15 years)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT & QUEEN ANNES HOSPITAL		d. STREET ADDRESS 205 WATER STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle OTTO Last CALL		4. DATE OF DEATH Month March Day 26 Year 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/10/1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY Kent & QA Equipment	9. AGE (In years last birthday) 65 yrs.
13. FATHER'S NAME WILLIAM HARDEN CALL		14. MOTHER'S MAIDEN NAME MARY LOUISE HUFFAR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 416-7673476	
17. INFORMANT WIFE + HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cat cell ca. of lung & metastasis 1621 DUE TO (b) Pneumonitis secondary to obstruction DUE TO (c) (item # 16 - (416 26 7636) Soc. Sec.)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Subendocardial infarction @ Fatty liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-24 , 19 67 , to 3-26 , 19 67 , that (I) (we) last saw the deceased alive on 3-26 , 19 67 , and that death occurred at 5:05 PM , from causes and on the date stated above.			
22a. SIGNATURE Harry P. Ross		22b. DATE SIGNED 3-27-67	
22c. PHYSICIAN'S NAME (Type) Dr. H. P. Ross		22d. ADDRESS CHESTERTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/28/67	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem.	23d. LOCATION (City or Town) (County) (State) Smyrna Del.
24. FUNERAL DIRECTOR W. Wells		25. RECORD BY REGISTRAR Mar 30 1967	
ADDRESS Chestertown, Md.		26. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03710									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HATTIE Middle DOWLING Last 4. DATE OF DEATH Month MARCH Day 6 Year 1967					5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH OCT. 21 - 1882 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY xx 11. BIRTHPLACE (County & State, or foreign country) Rock Hall MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME SAMUEL CANNAN 14. MOTHER'S MAIDEN NAME ANNA E. HIGGINS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 219-07-6764 17. INFORMANT BERTHA DOWLING - Rock Hall Md. Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cardio Vascular - Arterio sclerosis DUE TO (c) Atherosclerosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 67 , to March 7 , 19 67 and that death occurred at 19 M, from the causes and on the date stated above.									
22a. SIGNATURE Norbert C. Nitsch					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) NORBERT C. NITSCH					22d. ADDRESS Rock Hall, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF MAR. 9		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) (State) Rock Hall MARYLAND		
24. FUNERAL DIRECTOR Edgar D. Lane ADDRESS CHURCH HILL Md.					25a. REC'D BY REGISTRAR MAR 20 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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Great Western
Palm Springs
California

Thank You

April 10, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03705

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. Worton, Md.				c. LENGTH OF STAY IN ID Lifetime			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rauls Nursing Home				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. Worton, Maryland			
4. DATE OF DEATH Month 3 Day 14 Year 1967				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Elias Last Elias				4. DATE OF DEATH Month 3 Day 14 Year 1967			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/1891	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 14 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (County & State, or foreign country) Kent County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Elias				14. MOTHER'S MAIDEN NAME Ida (Unk.)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-9179		17. INFORMANT Mrs. Irene Elias Worton, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) old age							INTERVAL BETWEEN ONSET AND DEATH 2 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had hypertension since 1964.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-9, 1964 to 3-10, 1967 , that (I) (we) last saw the deceased alive on 3-10-1967 , and that death occurred at 10 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Rudolfs Eglitis				22b. DATE SIGNED 3-17-67			
22c. PHYSICIAN'S NAME (Type) Rudolfs Eglitis M.D.				22d. ADDRESS Rock Hall, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/1967		23c. NAME OF CEMETERY OR CREMATORY Fountain Methodist Cem.		23d. LOCATION (City, town or county) (State) R.R.D. Worton, Md.	
24. FUNERAL DIRECTOR Samuel W. Daley				25a. REC'D BY REGISTRAR DATE 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03706

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Chestertown, Md		c. LENGTH OF STAY IN Tb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle A. Last Johnson		4. DATE OF DEATH Month 3 Day 27 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1888
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months 14 Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Brown		14. MOTHER'S MAIDEN NAME Mary A. Graves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-30-8940	
17. INFORMANT Mr. George W. Johnson		Address Chestertown, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4221 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr M.D.		22. DATE SIGNED 3/28/67	
EXAMINER'S NAME (Type) Robert W. Farr M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/1967	23c. NAME OF CEMETERY OR CREMATORY EMMANUEL CEMETERY	23d. LOCATION (City or Town) (County) (State) R.F.D. Chestertown, Md
24. FUNERAL DIRECTOR Sonnet Waler		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Chestertown, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

03707

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Kent & Queen Anne's Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Thomas Johnson		4. DATE OF DEATH Month Day Year 3 - 26 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 15 94	9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MacK Johnson		14. MOTHER'S MAIDEN NAME Mr. Margaret Redding	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-20-0195		17. INFORMANT JOHN JOHNSON ST. 11 Pond, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Circumstances of this case are known to me - Robert Johnson, M.D., Kent County					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fraction Tibia Fibula Rt					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Getting out of car.			
20c. TIME OF INJURY Month, Day, Year Hour am 3.8 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Worton Kent Md	
21. I certify that (I) (this hospital) attended the deceased from 3.8 , 19 67 , to 3.26 , 19 67 , that (I) (we) last saw the deceased alive on 3.25 , 19 67 , and that death occurred at 7:12 AM, from causes and on the date stated above.					
22a. SIGNATURE Arthur T. Keefe M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3.26.67	
22c. PHYSICIAN'S NAME (Type) ARTHUR T. KEEFE		22d. ADDRESS CHESTERTOWN, MD			
23a. BURIAL, CREMATION, REMOVA. (Specify) BURIAL		23b. DATE THEREOF 7/1/67		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY	
23d. LOCATION (City or Town) ST. 11 Pond		(County) Kent		(State) Md	
24. FUNERAL DIRECTOR Donna Daley		ADDRESS Chestertown, Md		25a. REC'D BY REGISTRAR MAR 31 1967	
				25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000



03714

CERTIFICATE OF DEATH

03708

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY in 1b <u>1 hr. 50min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENT6 - QUEEN ANNES HOSPITAL</u>		d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH VIOLA LANDWEHR</u>		4. DATE OF DEATH Month Day Year <u>3 21 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>55 yrs</u> <u>7/25/11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>WALTER NEN MCKEIN</u>		14. MOTHER'S MAIDEN NAME <u>CLARA MAH COOPER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218 16 6732</u>	
17. INFORMANT <u>HOSPITAL RECORDS CHESTERTOWN, MARYLAND</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Ventricular fibrillation</u> DUE TO (c) <u>arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/21, 1967</u> , to <u>3/21, 1967</u> , that (I) (we) last saw the deceased alive on <u>3/21, 1967</u> , and that death occurred at <u>3:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Robert Farr</u>		22b. DATE SIGNED <u>3/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert Farr</u>		22d. ADDRESS <u>Chestertown, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestertown Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Chestertown, Md.</u>
24. FUNERAL DIRECTOR <u>J. Willis Wells</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
ADDRESS <u>Chestertown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with "Form" Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03715

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03709

1 PLACE OF DEATH a. COUNTY Kent MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY W. Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN Tb short	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) Washington Ave.		e. STREET ADDRESS 2805 Emerald Road	
3 NAME OF DECEASED (Type or print) Fred Leigh Noyes		4 DATE OF DEATH Month March Day 11 Year 1967	
5 SEX male	6 CO. OR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 22, 1915
9 AGE (In years last birthday) 51 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Martin-Marietta Co.		10b. KIND OF BUSINESS OR INDUSTRY Mass.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred S. Noyes		14. MOTHER'S MAIDEN NAME Edith Leigh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 015-12-3283	
17. INFORMANT LOUISA. Noyes		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Manner of death resembled circulatory arrest due to asysole or ventricular fibrillation. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Had had coronary heart disease and took nitro-glycerin as well as other cardiac drugs. While visiting			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION ON PART I (a) the college in Chestertown he went to the rest room and was found dead there.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20b. TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		22. DATE SIGNED 3/11/67	
EXAMINER'S NAME (Type) Robert W. Farr		Kent Co. Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/14/67	
23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR C. F. Evans & Son		25. RECEIVED BY REGISTERAR 8802 HANFORD RD	

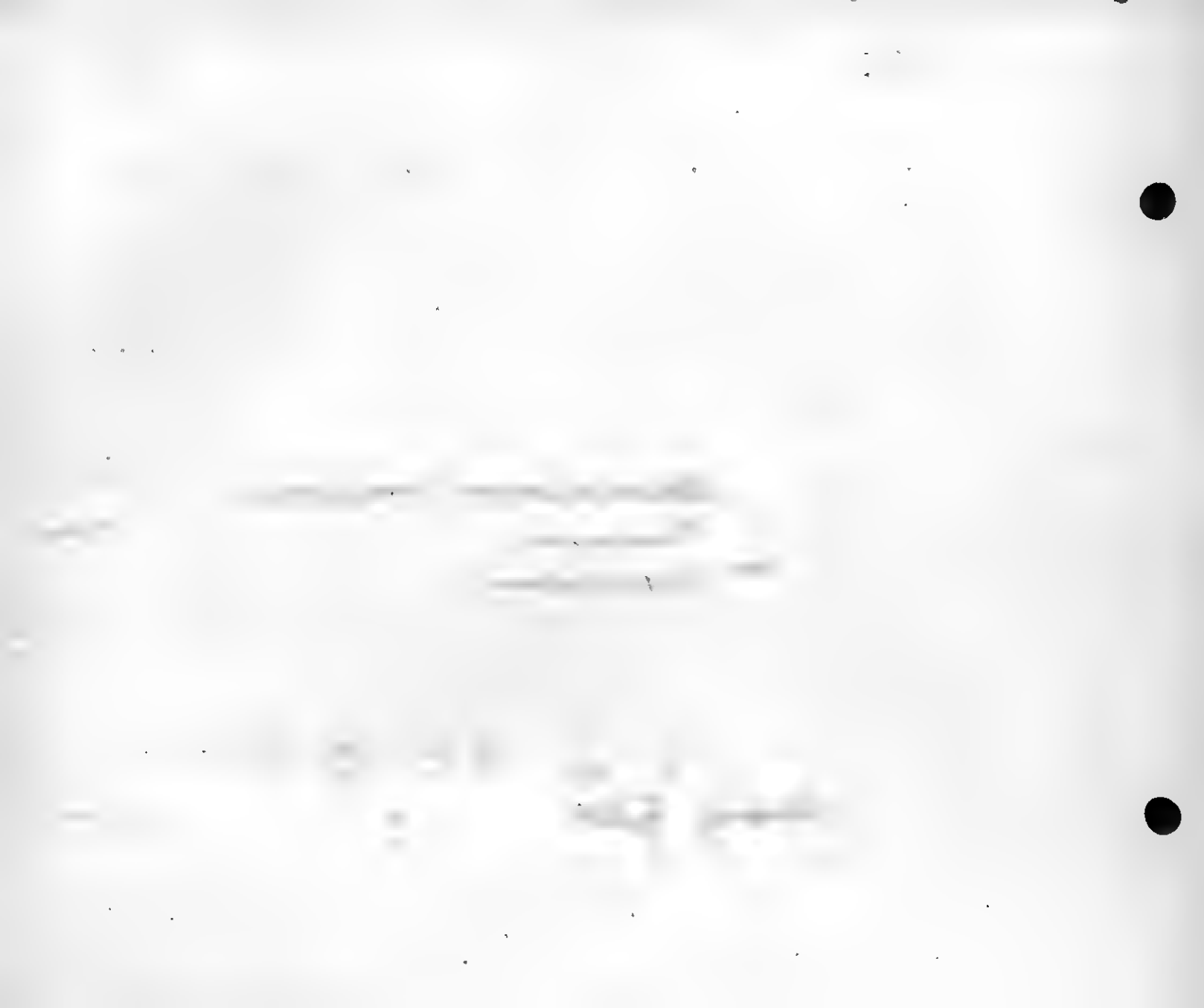
MAR 14 1967
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03716 CERTIFICATE OF DEATH 03716									
1. PLACE OF DEATH a. COUNTY <u>Kent County, Maryland</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. Chestertown, Md.</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. Chestertown, Maryland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>At Home</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Nellie</u>		Middle <u>Preston</u>		Last <u>Preston</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/15/1884</u>		9. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kent County, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>David Mable</u>					14. MOTHER'S MAIDEN NAME <u>Augustia Rail</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-18-6843</u>		17. INFORMANT <u>Mrs. Goldia Whitley Chester, Pa.</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular insufficiency</u> <u>475A</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-24, 1964</u> to <u>3-7, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-7-1967</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Rudolf Eglitis</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-10-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Rudolf Eglitis M.D.</u>				22d. ADDRESS <u>Rock Hall, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. DISGARD</u>			23d. LOCATION (City, town or county) (State) <u>Kent County, Maryland</u>		
24. FUNERAL DIRECTOR <u>James W. Valley</u>				ADDRESS <u>Chestertown, Md.</u>		25. REP'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

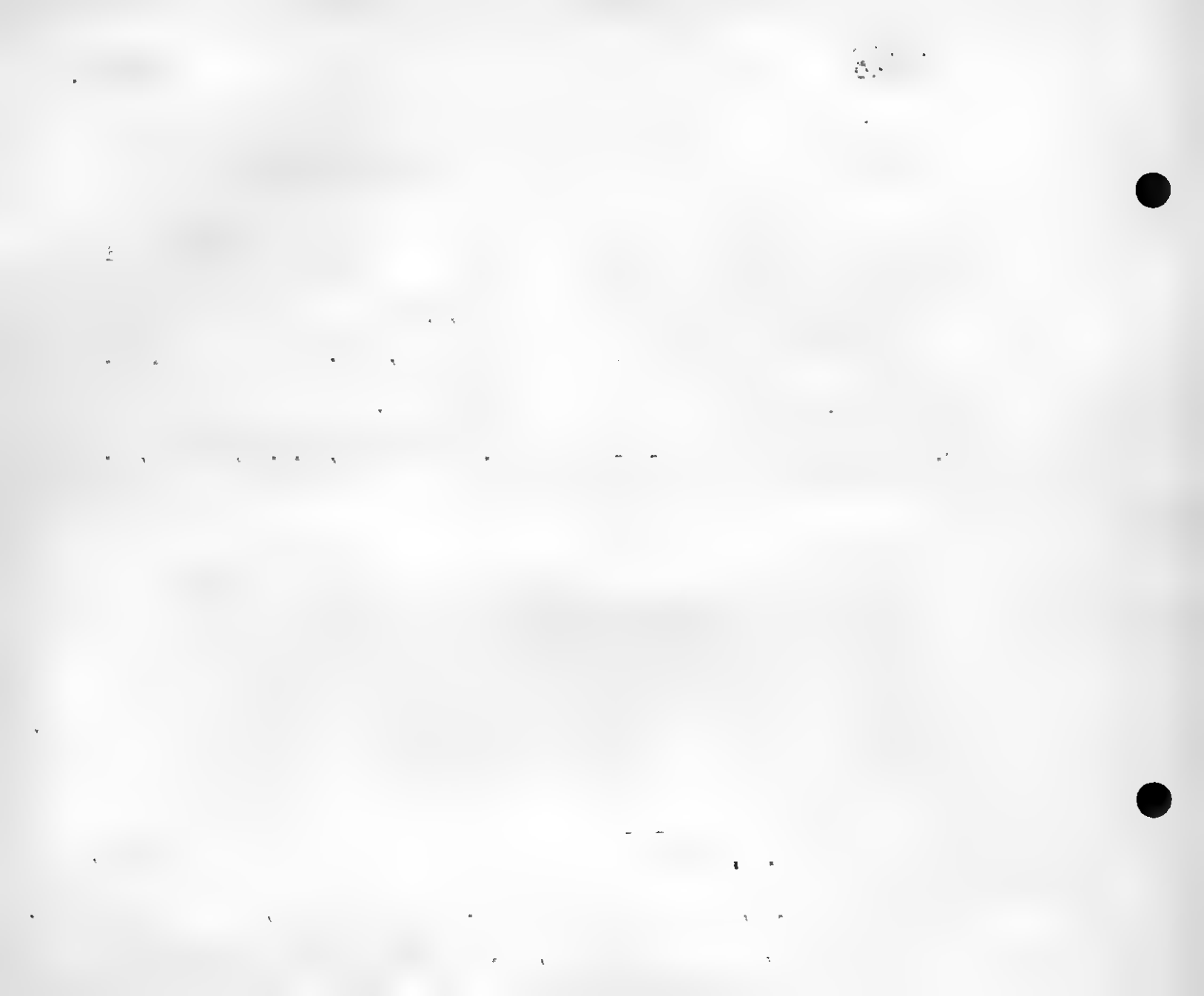
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03717

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03711

1. PLACE OF DEATH a. COUNTY Kent Ransom MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville, Md. (rural)			c. LENGTH OF STAY IN 1b Kennedyville (Md)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Floyd Ransom			4. DATE OF DEATH Month March Day 13 Year 1967		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1918	9. AGE (In years lost birthday) yrs 48	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming.		11. BIRTHPLACE (State or foreign country) Smyrna, Del.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Floyd Ransom.			
14. MOTHER'S MAIDEN NAME Mary Cox.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			
16. SOCIAL SECURITY NO. 218-12-2365		17. INFORMANT Address Mrs. Mary Taylor, R.D.#1, Elkton, Md. 21921			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY Multiple Severe Burns IMMEDIATE CAUSE (a) 9160 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)					INTERVAL BETWEEN DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(a)) Possible carbon monoxide poisoning (Blood taken for analysis)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I(a) of Item 18) Found dead in fire in house in which he was living			
20c. TIME OF INJURY Month Day Year 11:30 p.m. 3/11/ 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Kennedyville Kent Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert W. Farr		22. DATE SIGNED March 12, 1967		23. REGISTERAR'S SIGNATURE Charles Jones	
EXAMINER'S NAME (Type) Robert W. Farr		Address (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery.	23d. LOCATION (City or Town) (County) (State) Galena, Kent Md.		
24. FUNERAL DIRECTOR Edward Fellows,		ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR MAR 14 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

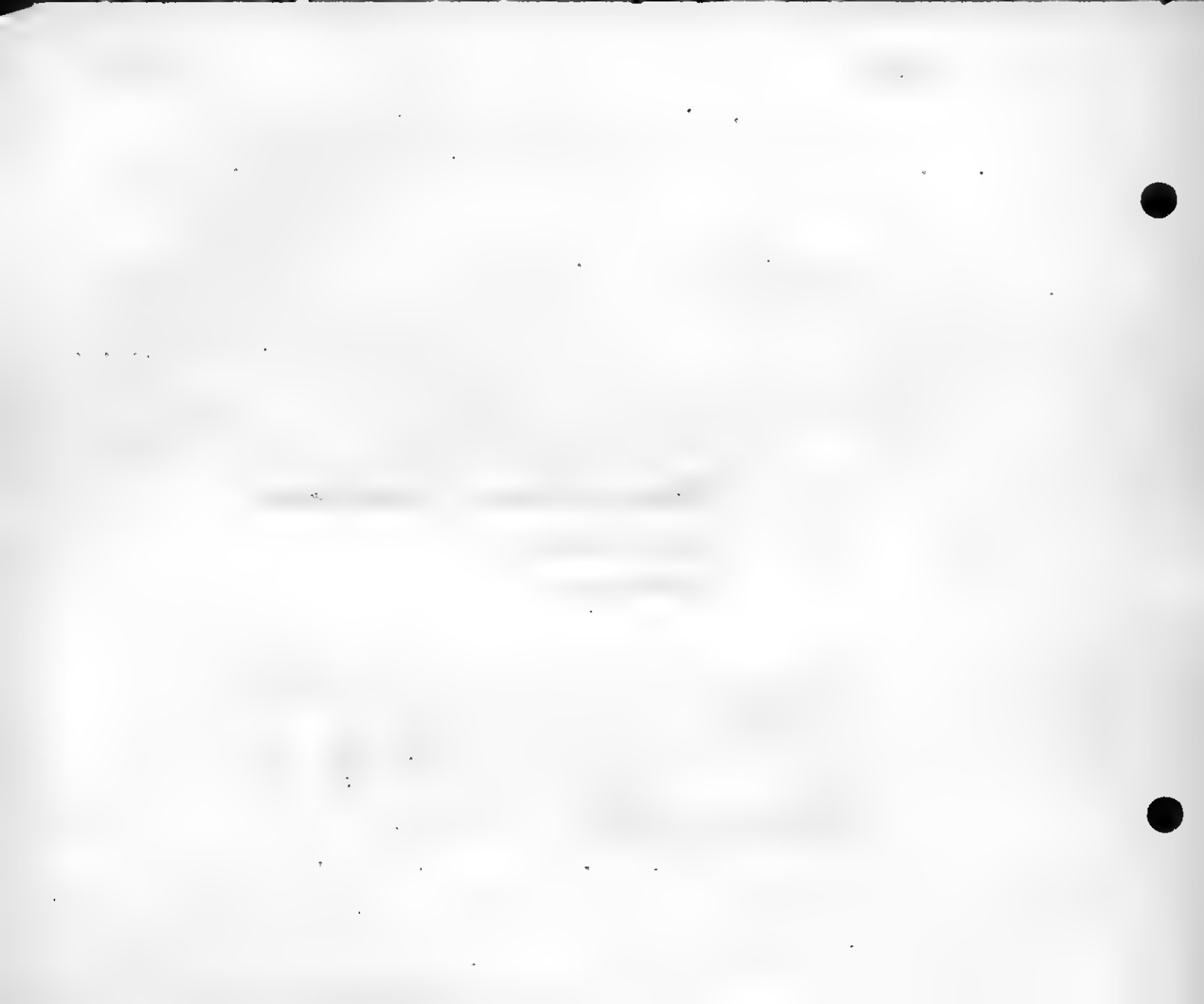
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03718

CERTIFICATE OF DEATH

03712

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Chestertown, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Chestertown, Maryland			
c. LENGTH OF STAY in lb Lifetime				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lula Middle J. Last Scott				4. DATE OF DEATH Month 3 Day 14 Year 1967			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/1878	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8		IF UNDER 24 HRS. Hours 8 Min. 8			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Johnson				14. MOTHER'S MAIDEN NAME Martha Rasin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Charleston Scott Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular insufficiency DUE TO (b) Arterio sclerosis DUE TO (c) Old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 14 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1-9-1967 , to 3-14-1967 , that (I) (we) last saw the deceased alive on 3-10-1967 , and that death occurred at 1A M, from the causes and on the date stated above.							
22a. SIGNATURE Rudolf Eglitis				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-14-67	
22c. PHYSICIAN'S NAME (Type) Rudolf Eglitis M.D.				22d. ADDRESS Rock Hall, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/1967		23c. NAME OF CEMETERY OR CREMATORY Asbury Methodist Cem.		23d. LOCATION (City, town or county) (State) Kent County, Maryland	
24. FUNERAL DIRECTOR Charles Judge				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR 21 1967	
						25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

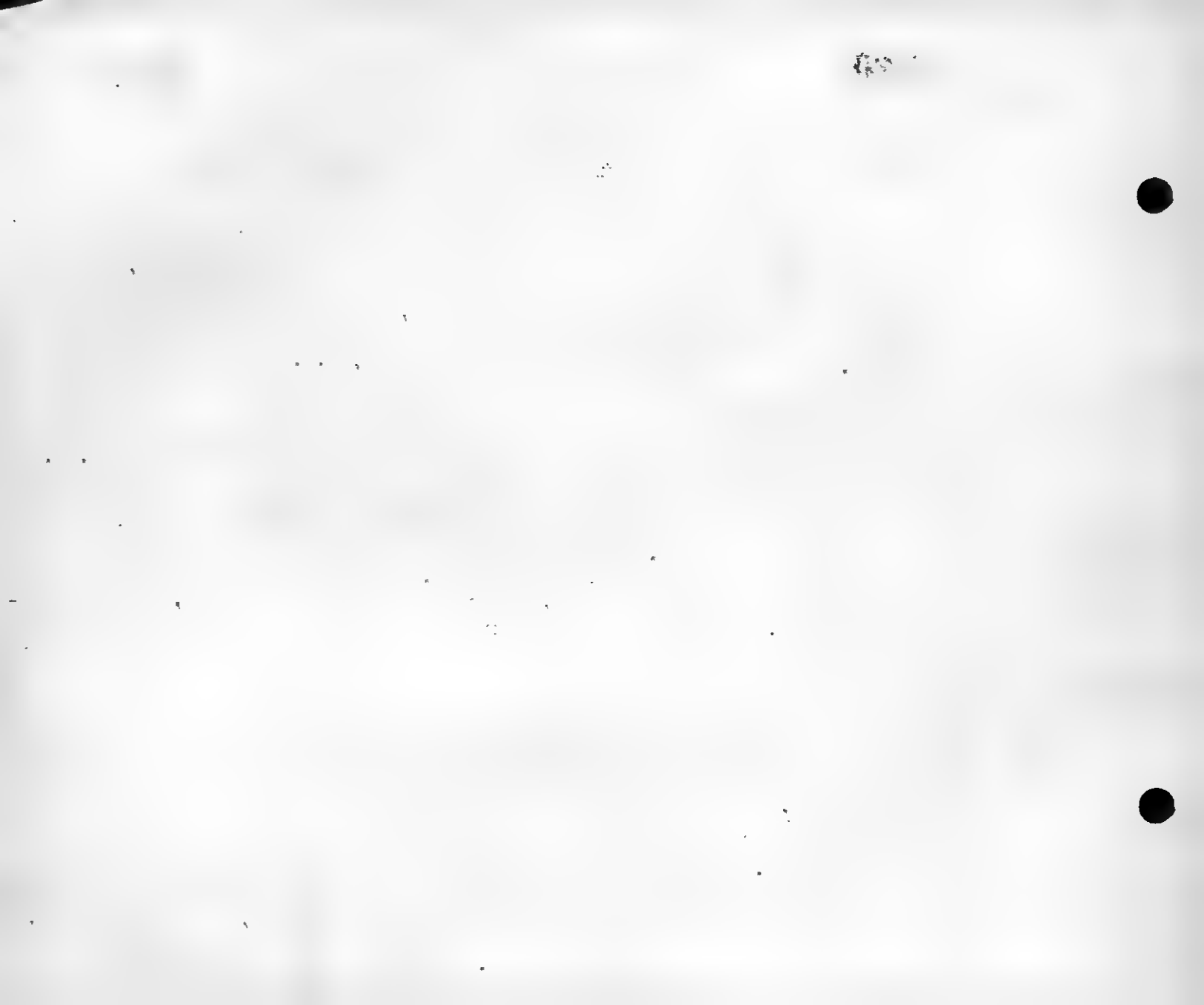
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03713

1 PLACE OF DEATH a. COUNTY Kent MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE New Jersey b. COUNTY Marlton	
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Millington (rural)		c. LENGTH OF STAY IN TB in transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		d. STREET ADDRESS WILLOW BEND RD	
3 NAME OF DECEASED (Type or print) Esther M Westcott		4 DATE OF DEATH Month March Day 23 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept 12, 1887
9 AGE (in years last birthday) yrs 79		IF UNDER 1 YEAR Months 2 Days 12 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (State or foreign country) Marlton, N. Jersey		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Morrison		14 MOTHER'S MAIDEN NAME Margaret Hpltz	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO NONE	
17 INFORMANT Ricard Westcott (husband)		Address Marlton, N. J.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease DUE TO Had been under treatment for heart disease for a long time. Was traveling home from Florida in the company of her son and her husband. Stopped at a Roadside restaurant for breakfast, and collapsed at the entrance, and apparently died quickly. Attempts at resuscitation by persons nearby were ineffective. (b) time. Was traveling home from Florida in the company of her son and her husband. Stopped at a Roadside restaurant for breakfast, and collapsed at the entrance, and apparent- (c) for breakfast, and collapsed at the entrance, and apparent-		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ly died quickly. Attempts at resuscitation by persons nearby were in-effective		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		22. DATE SIGNED 3/25/67	
EXAMINER'S NAME (Type) Robert. W. Farr		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) (KENT)	
23a. BURIAL CREMATION, etc. Burial	23b. DATE THEREOF 28 MAR 1967	23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery	23d. LOCATION (City or Town) (County) (State) Marlton, N.J.
24 FUNERAL DIRECTOR Edward Fellows,		25a. REC'D BY REG. STRAR MAR 28 1967	
ADDRESS Millington, Md.		25b. REGISTRAR'S SIGNATURE g Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

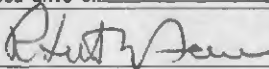

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03720

03714

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 206 Washington Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Worton d. STREET ADDRESS 141 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First George Middle Thomas Last Williams Sr.				4. DATE OF DEATH Month March Day 18 Year 19 67					
5. SEX male		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1885		9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR: Months 81 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (County & State, or foreign country) Worton, Kent, Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Thomas Williams						14. MOTHER'S MAIDEN NAME Sarah Matilda Porter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 220-34-9474		17. INFORMANT Marvin V. Williams, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4221 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe primary anemia - type undetermined								INTERVAL BETWEEN ONSET AND DEATH several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/1/1965 , to 3/18, 1967 , that (I) (we) last saw the deceased alive on 3/18, 1967 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE 						22b. DATE SIGNED 3/20/67			
22c. PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.				22d. ADDRESS Chestertown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.			
24. FUNERAL DIRECTOR Marvin V. Williams, Chestertown, Md.				25a. REC'D BY REGISTRAR MAR 23 1967		25b. REGISTRAR'S SIGNATURE 			

03716

03716

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

FOR THE DIRECTOR, AGRICULTURAL RESEARCH SERVICE

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE

FROM:

DATE:

SUBJECT:

RE: [illegible]

1/10/64

03721

CERTIFICATE OF DEATH

03715

1. PLACE OF DEATH a. COUNTY Kent County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes Hospital		d. STREET ADDRESS 126 Queen Street	
3. NAME OF DECEASED (Type or print) Florence Gladys Workman		4. DATE OF DEATH Month March Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-21-1887
9. AGE (In years and birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hotel keeper - Country Cousin Inn	
11. BIRTHPLACE (County & State, or foreign country) New York City, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk Elliott		14. MOTHER'S MAIDEN NAME Mary Klein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-20-9744	
17. INFORMANT Mrs. William Wessell		Address Lynch, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Acute Myocardial Infarction DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 7 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atelactasis with associated Pneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/21 , 19 67 to 3/2 , 19 67 , that (I) (we) last saw the deceased alive on 3/2 19 67 and that death occurred at 6:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Thomas J. Solon		22b. DATE SIGNED 3/3/67	
22c. PHYSICIAN'S NAME (Type) Thomas J. Solon M. D.		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/5/67	23c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery	23d. LOCATION (City or Town) (County) (State) Still Pond, Md.
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR DATE MAR 6 1967	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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03751

03751